sensibly into a cancerous diathesis. Mr. Hilton, in the present case, looked rather in a psychological way at the operation, as relieving the woman's mind of much misery and apprehension, leading to dyspepsia, etc., this dyspepsia aggravating the cachexia already so liable to increase.—*Assoc. Med. Journ.*, June 14, 1856.

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26. *Tumours of the Upper Maxilla, malignant and non-malignant.*—Mr. Fergusson removed a tumour of the upper jaw on the 21st ult., of the "compact osseous" character, by an operation we have often seen. The tumour had been growing for twelve months, and had pushed the inferior turbinated bone inwards, so as to make a projection in the nostril. Mr. Fergusson divides the lip in the mesial line, thus happily making a "virtue of necessity," and converting what might be an ugly scar into a linear wound of little moment. This, in an operation of *convenance*, as the French term it, is a matter of no small anxiety; but the mechanical aptitude of the Surgeon of King's College Hospital is so well known that we did not fear for the result. Mr. Fergusson divided the lip, as we said, in the median line, and then dissected, in the usual familiar manner, the tissues of the cheek off the tumour. There was nothing, however, in the operation that our provincial brethren are not conversant with. The disease was simple hypertrophy of the osseous structure, fortunately not malignant.

A tumour of a still more interesting character was removed by Mr. Corlino, April 25th, at the London Hospital. Here the tumour was situated above the alveolar processes of the molar teeth, on the right side, expanding the bone in the mode so familiar to hospital surgeons. The common directions followed by Mr. Fergusson, of making the first incision in the mesial line, did not answer; and Mr. Curling wisely preferred not to cut uselessly through parts not diseased, as a matter of *convenance* and credit for the operator, but, in the first place, to consult what was best for the patient, even at the risk of a little deformity. Mr. Curling's incision, accordingly, as he found he could not obtain space to work in by the mesial incision, was made ingeniously through a dimple in the cheek. From a long familiarity with Mr. Curling's excellent operations, we do not know but that in special instances one would give a preference to his operation, especially in men, where the beard will cover over the scar; but in females, the plan of incision in the mesial line at some little risk of injuring vital parts may be adhered to. The tumour in Mr. Curling's case was examined by Dr. Andrew Clark, when it proved to be one of the familiar —we had almost said endless—varieties of growths, so often met in hospitals, which Mr. Paget would class perhaps under myeloid tumours, the Middlesex Hospital school under the class of "colloid growth," but which Dr. Andrew Clark showed to be made up of both, together with epithelial cells in various shapes, and fat-globules—a tumour, in a word, which abstract histological data would rather surround with mystery, and experience alone decide as to malignancy.—*Assoc. Med. Journ.*, May 2, 1856.

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27. *On Gangrene from Arteritis.*—The following are some of the conclusions arrived at by Prof. Porta, from the observation of thirty-one cases of his own, and the consideration of those published by others:—

Although the tunics of arteries consist of tissues little disposed to inflammation, yet are they not exempt from liability to it; and external violence, the extension of phlegmasia from other tissues, rheumatism or metastasis may induce an arteritis that may lead to gangrene of subjacent parts. Among all these causes, metastasis is pre-eminent, so that eighteen out of the thirty-one cases are referable to it. Not unfrequently, on the decline or disappearance of some serious internal malady, a reverberation is directed to the arteries of the limbs, the original disease either then disappearing, or remaining as a complication of the newly-developed arteritis. The large external arteries, such as the axillary, humeral, femoral, or popliteal, are usually the subjects of such reverberation, but it has not as yet been met with in the carotid. Exceptionally, smaller arteries are attacked, such as the radial, ulnar, or tibial.

The end to which arteritis tends is the closure of the artery, all the manifesta-

tions observed subsequent to the cessation of its pulsation being but the sequelæ of that. Strictly speaking, however, such cessation of pulsation is not pathognomonic of obliteration, as sometimes a minute stream continues to pass, which excites so feeble an oscillation of the vessel as not to be perceptible to the touch. The obstruction of the artery does not necessarily give rise to gangrene, for not only may it be incomplete, but even when complete, it may have been formed with sufficient slowness to allow the development of the lateral anastomoses; the amount of the obliteration, indeed, exerting less influence than the rapidity with which the coagulum is formed. This local condition is not the sole cause of the gangrene, for the production of this may be favoured by a disordered state of the general circulation, or a temporary enfeeblement of the cardiac impulse. There is, however, no lesion of the function of the capillaries operating, as the minute vessels are found healthy and empty in the midst of the gangrened parts, just as they are in mortifications that supervene upon ligature. Gangrene from arteritis presents a great analogy to senile gangrene, which may take place slowly or rapidly, according to the amount of ossific deposit, and the other conditions of the subject.

There is nothing constant observed as regards the form, extension, or duration of this result of arteritis. Sometimes the patient dies during the prodromic stage, in consequence of the rapid exhaustion of his powers before the limb has mortified. In other cases, there are eschars, limited to the skin, or the gangrene may attack only one or more toes. Frequently, however, it extends to the foot and leg, or the hand and forearm, until the power of the lateral circulation restores the equilibrium, if it succeed in so doing. If even it is arrested, there is a disposition to relapse; and a paresis, and temporary or permanent atrophy of the limb, remains. Danger to life, however, is not alone dependent upon the degree of extension of the gangrene, but also upon the general state; this allowing us sometimes to hope for recovery in even extensive gangrene, while at others it renders a limited gangrene a most grave circumstance. So dangerous an affection is it, that few succeed in escaping from its effects.

Besides the internal changes that may exist as the effects of the malady which has also caused the arteritis, we often find in the artery supposed to be affected but slight traces of lesions. In bad cases, however, a sero-gelatinous fluid is found external to the artery, the cellular coat is finely injected, and the proper tunics are adherent to each other, and fragile. Sometimes there is thickening of the cellular tunic, and exudation of puriform matter or plastic lymph, externally to the vessel, affixing it to neighbouring parts. All these lesions are not of frequent occurrence in arteritis; and except in the case of violence, all the coats of the vessel may present a normal appearance, and they would be so pronounced, were it not for the obstruction caused by the product of inflammation. This consists of a solid coagulum of plastic lymph, varying in size, length, and degree of adhesion to the vessel. Sometimes small coagula are observed obstructing the artery at intervals; but more commonly it is a single coagulum, one or more inches in length, converting the vessel into a cord. Sometimes, however, the coagulum assumes the form of a canal, or presents here and there small lacunæ, containing a milky or semi-fluid reddish matter, which may also cover the whole surface of the coagulum, or almost constitute its entire substance. Maisonneuve and Cruveilhier have found even the smallest vessels corresponding to the gangrened part obliterated; but, for the most part, the closure will be found only in the vessels above the gangrened part, those corresponding to this remaining open—showing that the coagulum has preceded the gangrene.

The principal veins of the limb sometimes participate in the inflammatory condition, and exhibit the signs of this more plainly than do the arteries. Their coats become thickened, and rich in vasa vasorum; while their cavity is filled with lymph, or, oftener still, by puriform matter combined with cruor. In ordinary cases, however, the principal veins remain free, contain a small quantity of blood, in part fluid and in part coagulated, or, without exhibiting any signs of phlegmasia, are obstructed by a sanguineous coagulum.

As the arteritis is unpreceded by any prodrome, no prophylactic can be employed; but in order to prevent or circumscribe the formation of coagula, the

arteritis itself must be actively combated by antiphlogistic means, general or local, according to the amount of reaction and the condition of the patient. These must, however, be employed with due caution; for while we combat the inflammatory action, we have to favour the lateral circulation. As soon as the more urgent symptoms are mitigated, aromatic fomentations or warm applications should be made to the part, improving the patient's diet, and even exhibiting stimuli, if not specially contra-indicated. If the pain is violent, opium is here, too, of great use. These means are, however, often of no avail; for the arteritis, especially when metastatic, appears suddenly, gives rise to the exudation, and at once disappears; gangrene following if the lateral circulation cannot resist, and leaving to the practitioner only the office of administering palliatives. So, too, all attempts at dissipating the coagulum are useless, this remaining even in the case of recovery; and all that can be done is to endeavour to limit it by favouring the lateral circulation. Even in the case of recovery, until the circulation is completely re-established, there is great danger of relapse.—*B. and F. Med.-Chirurg. Rev.*, from *Omodei Annali di Med.*, Feb., 1856.

28. *New Mode of Reducing Strangulated Hernia.*—Baron Seutin declares, that with his mode of reducing strangulated hernia, which he has now practised for twenty years, he hardly ever, in his large practice, finds it necessary to have recourse to an operation.

The patient is laid upon his back, with the pelvis raised much higher than the shoulders, in order that the intestinal mass may exert traction upon the herniated portion. The knees are flexed, and the body is slightly turned to the opposite side to that on which the hernia exists. The surgeon ascertains that the hernia, habitually reducible, cannot be returned by continuous and moderate taxis. He next seeks with his index finger for the aperture that has given issue to the hernia, pushing up the skin sufficiently from below, in order not to be arrested by its resistance. The extremity of the finger is passed slowly in between the viscera and the hernial orifice, depressing the intestine or omentum with the pulp of the finger. This stage of the procedure demands perseverance, for at first it seems impossible to succeed. The finger is next to be curved as a hook, and sufficient traction exerted on the ring to rupture some of the fibres, giving rise to a cracking very sensible to the finger, and sometimes to the ear. When this characteristic crack is not produced, the fibres must be submitted to a continuous forced extension, which, by distending them beyond the agency of their natural elasticity, generally terminates the strangulation. This mode of procedure is more applicable to Gimbernat's ligament, the hooking and tearing of which are more difficult than in the case of the inguinal ring. Considerable strength has sometimes to be exerted, and the index finger becomes much fatigued. When, in consequence of the narrowness of the ring, the finger does not at once penetrate, it is to be pressed firmly against the fibrous edge, and inclined toward the hernia. After a time the fibres yield and the finger passes. When the finger becomes fatigued it is not to be withdrawn, but it should be supported by the fingers of an intelligent assistant, who seconds the action it is desired to produce. In inguinal hernia, the traction should not be exerted with the finger upon Pouport's ligament, but in a direction from within outwards, and from below upwards, by which the aponeurotic layers between the two ligamentous pillars constituting the inguinal aperture are easily torn through.

The ring is then enlarged by this tearing, just as if it had been divided by a cutting instrument, or largely dilated, and reduction takes place easily, by performing the taxis in a suitable direction. The mobility of the skin, its laxity in parts where hernia prevails, and its extensibility, greater in proportion to its thinness and to the absence of a lining of fatty cellular tissue—by allowing the sliding and the thrusting of this membrane in front of the finger it cushions, affords protection to the intestine from all immediate contusion. When the strangulation is induced by the issue of a considerable mass of intestine, or an accumulation of fecal matters, it is desirable first to disengage one of the extremities of the noose, and to seek to expel the gas or fecal matters by moderate pressure, in order to facilitate the reduction of the tumour. In the few cases